DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	08A011	A. BUILDING _____ B. WING _____	C 07/03/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIVE STAR FOULK MANOR NORTH LLC	1212 FOULK ROAD WILMINGTON, DE 19803

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Annual and complaint visit survey was conducted at this facility from June 26, 2012 through July 3, 2012. The deficiencies contained in this report are based on observations, interviews, review of resident's records and review of other documentation as indicated. The facility census the first day of the survey was 12 Medicaid including 1 bed hold. The Stage II sample totaled 11 residents.	F 000	Responses to the cited deficiencies do not constitute an admission of agreement by Foulk Manor North of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The plan of correction is prepared solely as a matter of compliance with federal and state law.	
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another	F 164	A. On June 28, 2012 and July 3, 2012, the facility immediately addressed the identified team member/hospice nurse responsible for failing to ensure each resident's privacy. Both team members understand the importance of respecting resident privacy. On July 30, 2012 the facility installed a privacy curtain along the track surrounding the toilet seat in the second floor tub room. B. The Social Services Director will conduct a resident's rights/dignity and sensitivity training to all nursing personnel. The Director of Nursing or designee, will schedule an in-service to all nursing personnel on the importance of providing services to residents in resident rooms or private areas. The Director of Nursing and Social Services Director or designee, will schedule a meeting with all hospice providers who are providing services to the residents at Foulk Manor North, to review the findings and facility policies and practices as it relates to resident rights/dignity.	8/17/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Victoria A. Gray NHA | EXECUTIVE DIRECTOR | August 2, 2012

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	08A011	A. BUILDING _____ B. WING _____	C 07/03/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIVE STAR FOULK MANOR NORTH LLC	1212 FOULK ROAD WILMINGTON, DE 19803

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 164	Continued From page 1 healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to provide personal privacy for 1 (R13) out of 11 stage II sampled residents. Also, the facility failed to provide a privacy curtain for toilet use in the 2nd floor bath. Findings include: The Morning Care Policy and Procedure, dated 1/1/01, was reviewed and included, "Fundamental Information... equipment to obtain vital signs if needed; Procedure 1. Assemble equipment and provide privacy..." 1A. On 6/28/12 at 2 PM, E9 (Hospice RN) was observed greeting R13 who was seated in a wheelchair adjacent to the nurses' station. E9 then pushed R13 a few feet, sat in the recliner adjacent to the nurses' station and proceeded to place his stethoscope to listen to the resident's heart and take R13's blood pressure with other residents present including R3, R15 and R16. The facility failed to ensure R13's privacy. On 6/28/12, in an interview with E7 (LPN), he confirmed that R13 should have been taken back to her room to be examined by the hospice nurse in a private place. 1B. On 7/3/12 at 2:07 PM, an observation was made of R13 having her temperature taken by E12 (LPN) while sitting in a wheelchair across from the nurses' station with other residents	F 164	C. The Director of Nursing and Social Services Director or designee, will conduct weekly observation rounds to ensure that all licensed and certified professionals are respecting resident privacy and dignity and document findings on Weekly Observation Log Sheet. The Social Service Director or designee will review the Weekly Observation Log Sheet during weekly care plan meetings. D. The Director of Nursing and Social Services Director will review all findings of the Weekly Observation Log Sheet during the facility's Quarterly Quality Assurance Meetings for six (6) months.	8/17/12

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	08A011	A. BUILDING _____ B. WING _____	C 07/03/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIVE STAR FOULK MANOR NORTH LLC	1212 FOULK ROAD WILMINGTON, DE 19803

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 164	Continued From page 2 present including R15 and R19. The facility failed to ensure R13's privacy. On 7/3/12, in an interview with E12, she stated she knew that it was wrong and should have taken the resident back to her room, "I'm sorry".	F 164		
F 280 SS=D	2. On 6/28/2012 at 10:05 AM during an environmental tour of the second floor bath, it was revealed that a track was missing a toilet privacy curtain. Interview with E6 (CNA) on 7/3/2010 at 8:40 AM confirmed that the track for a privacy curtain was missing. 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.	F 280	A. No residents were affected by this deficient practice. B. The Assistant Director of Nursing or designee will conduct in-servicing with all licensed professionals, on proper care plan documentation and measurable interventions and outcomes. C. The Unit Managers or designee, will review care plan documentation from the twenty-four (24) hour report, daily and re-educate nurses as necessary and report findings to the Director of Nursing or designee weekly. D. The Director of Nursing will review all care plan findings during the facility's Quarterly Quality Assurance Meetings for six (6) months.	8/17/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	08A011	A. BUILDING _____ B. WING _____	C 07/03/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIVE STAR FOULK MANOR NORTH LLC	1212 FOULK ROAD WILMINGTON, DE 19803

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 3	F 280		

This REQUIREMENT is not met as evidenced by:
Based on record review and interview, it was determined that the facility failed to ensure that two (R4 & R5) out of 11 stage II sampled residents' care plans were reviewed and revised after each assessment. The care plan for R5 was revised, however the information recorded on the care plan failed to demonstrate how the facility evaluated the objectives listed on the care plan. The care plan for R4 failed to include the interventions provided by the hospice aide.
Findings include:

1. R5's care plan initiated on 7/24/11, and last reviewed and revised on 6/25/12 entitled, "Total assist with ADL (Activities of Daily Living/Functional Status) care" had the following interventions:
Provide total assist for personal hygiene;
offer choices as able in clothing selection between 2 equally acceptable choices;
Provide total assist with incontinent care;
PROM (Passive Range of Motion) daily
Make items accessible to resident;
Transfer with 2 person assist using stand up lift;
halo Bars to B/L side of bed to assist with turning and repositioning;
may use Paratransit w/o companion;
Motorized wheelchair can be manually moved;
2/29/12 May change colostomy bag independently as needed.

The care plan was revised on 6/20/12, 6/25/12, 6/26/12. However, the interventions documented

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	08A011	A. BUILDING _____ B. WING _____	C 07/03/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIVE STAR FOULK MANOR NORTH LLC	1212 FOULK ROAD WILMINGTON, DE 19803

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 4 in the care plan for these dates failed to reflect steps that conform with the objectives of the identified ADL problem to enhance R5's ability to meet the ADL objectives and evaluate its effectiveness. The following additional problems and approaches were documented during the dates of revision that did not conform to or reflect the care plan entitled, "Total Assist with ADL care problem": 6/20/12 Mucinex 600 mg (milligrams) 1 po (by mouth) BID (twice a day) x (times) 7 days-encourage PO (oral) fluids; 6/25/12 Schedule cardio follow-up secondary to episode of CHF (Congestive Heart Failure); 6/26/12 hold Coumadin on 6/26/12 and 6/27/12; Coumadin 1.5 mg po on 6/28/12; DC (discontinue) current Coumadin orders; PT/INR (lab work) on 6/29/12; Call .... w (with) PT/INR results on 6/29/12; 6/27/12 Zyrtec 10 mg po daily OK to administer @ 0800 AM. In addition, the problems that were additionally documented in this care plan were: 12/12/11 Heme test to check for blood in stools x 3; 6/20/12 check CXR (chest xray) and labs to R/o (rule out) RLL, PNA stat (to rule out Right Lower Lobe pneumonia); 6/25/12-repeat CXR on 6/27/to f/u (follow up) CHF. This finding was discussed and acknowledged on 7/3/12 by E1(Administrator), E2 (Director of Nursing) and E3 (RN).	F 280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	08A011	A. BUILDING _____ B. WING _____	C 07/03/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIVE STAR FOULK MANOR NORTH LLC	1212 FOULK ROAD WILMINGTON, DE 19803

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 5 Cross refer F312 2. On 6/29/12 at 11:03 AM, the surveyor requested to review the documentation of the hospice care provided to R4 that morning. E11 (nurse) was unable to find E10 (hospice CNA) and stated that she must have already left the building. The same information was requested from E2 (Director of Nursing), who reviewed the hospice books and acknowledged that there was no documentation for the care provided regarding R4 on 6/29/12. The last documentation was dated 6/27/12. Approximately, two hours later, E2 returned with copies of "Hospice Aide/Homemaker Note" documentation of the care provided to R4 for the "past 30 days" which the hospice service had faxed to the facility at 12:35 PM. However, there was no documentation for 6/29/12. During an interview on 7/3/12, E2 reviewed the hospice book which now had documentation of a "Routine Aide visit" on 6/29/12, 7/2/12 and 7/3/12 by E10 (hospice CNA). E2 provided an additional "Hospice Aide/Homemaker Note", dated 6/29/12, which was faxed to the facility on 7/3/12 at 2:50 PM. This CNA note stated that E10 had visited R4 on 6/29/12 from 7:40 AM to 9:00 AM and provided care that included "Oral Hygiene: Brush mouth with toothettes Apply lip balm..." E2 acknowledged that this documentation was inaccurate and not consistent with the observations and interviews of 6/29/12 when it was discovered that oral care had not been provided to R4 by E10.	F 280		
F 309 SS=E	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING	F 309		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	08A011	A. BUILDING _____ B. WING _____	C 07/03/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIVE STAR FOULK MANOR NORTH LLC	1212 FOULK ROAD WILMINGTON, DE 19803

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 6 Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review, interview and observation, it was determined that the facility failed to ensure that one (R5) out of 11 stage II sampled residents received/was provided the necessary care and services during resident transfer from one surface to another surface using a stand up lift to attain or maintain this resident's highest practicable physical well being in accordance with the assessment and plan of care. Additionally, the facility failed to ensure that R5 received medication as ordered by the physician. There were 16 occurrences when R5 received Zyrtec in the morning when the physician's plan of care stated at bedtime. Findings include: 1A. R5 had diagnoses which included CVA (stroke) with left hemiparesis, and degenerative joint disease. According to the quarterly Minimum Data Set (MDS) assessment, dated 3/31/12, R5 was totally dependent on staff for transfer with 2 person assist for bathing, toilet use and personal hygiene. R5 had contractures on the left shoulder, left elbow, left wrist, left hip, left knee and right knee. The facility initiated a care plan on 7/24/11 which	F 309	A. The facility immediately addressed the identified team member responsible for failing to properly follow the transfer precautions outlined in the resident's care plan. The team member now understands the importance of reviewing all residents plan of care and company transfer policy. With regard to the medication findings, there was no adverse reaction. B. The Assistant Director of Nursing or designee will conduct in-servicing with all nursing staff on proper use of the mechanical lift and following resident care plans. The Assistant Director of Nursing will conduct in-servicing with all licensed professional staff on the importance transcribing physician's orders properly. C. The Unit Manager or designee will make observation rounds daily, to monitor staff during care giving for proper safety techniques and report findings weekly to the Director of Nursing or designee. The 11-7 nursing will conduct nightly chart checks to ensure no errors were made and report findings to the Unit Manager or designee any errors that are found.	8/17/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	08A011	A. BUILDING _____ B. WING _____	C 07/03/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIVE STAR FOULK MANOR NORTH LLC	1212 FOULK ROAD WILMINGTON, DE 19803

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 7 was last reviewed on 6/25/12, for "Total assist with ADL care". The care plan intervention included: Transfer with 2 person assist using stand up lift. On 7/2/12, it was observed that E13 (CNA) who was caring for R5, transferred this resident from the bed to the chair using the stand up lift without the assistance of another staff member. On 7/3/12 at approximately 9:30 AM, R5 was observed being transferred from bed to her wheelchair without the assistance of another staff member prior to receiving a whirlpool bath. E13 again transferred R5 using a stand up lift without the assistance of another staff member both into and out of the whirlpool tub. R5 complained that she was getting tired standing using the stand up lift while E13 was putting on R5's adult disposable brief. On 7/2/12, in an interview, E2 (DON) and E3 (RN) confirmed that 2 staff members were required when using the stand up lift for transfers. Additionally, on 7/3/12, this finding was confirmed by E13 (CNA) and E14 (ADON). 1B.Review of the physician order sheet revealed that R5 had an order of Zyrtec 10 mg (milligrams) PO (by mouth) Q (every) HS (bedtime). The prescribed medication was incorrectly transcribed on R5's MAR (Medication Administration Record) as "Zyrtec 10 mg PO OD"(orally once a day) and timed 8:00 AM. Zyrtec was administered to R5 at 8:00 AM	F 309	D. The Director of Nursing will review all findings during the facility's Quarterly Quality Assurance Meetings for six (6) months. [illegible] July 16, 2012	8/17/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	08A011	A. BUILDING _____ B. WING _____	C 07/03/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIVE STAR FOULK MANOR NORTH LLC	1212 FOULK ROAD WILMINGTON, DE 19803

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 8 instead of at bedtime for 16 days. This finding was discovered during the medication pass physician's order reconciliation. The facility failed to follow the physician's plan of care for administration of the Zyrtec.This finding was confirmed with E12 (LPN) on 6/28/12.	F 309		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, record review, it was determined that the facility failed to ensure that one (R4) out of eleven (11) stage II sampled residents received the necessary services to maintain oral hygiene as per her plan of care. Findings include: Review of R4's annual Minimum Data Set (MDS) assessment, dated 3/16/12, indicated that the resident was dependent on staff for personal hygiene including mouth care and was receiving hospice services. R4 had a current (June 2012) physician order which originated on 1/5/10 for oral care twice a day and to monitor gums. R4's care plan for "ADL (Activities of Daily Living) Deficit" initiated 3/12/12, included the approach,	F 312	Cross refer F280 A. On 6/29/12, after being made aware of the surveyor's findings, the facility immediately transported the resident to her room and provided oral care. B. The RN Supervisor will randomly select three residents, on the 7-3 and 3-11 shift, daily, to ensure that proper mouth care has been provided and will immediately address any findings at the time of any occurrence. The Director of Social Services will conduct a resident rights/dignity and sensitivity training to all nursing personnel. C. The Director of Nursing and Social Services Director or designee, will discuss any findings with all hospice personnel, who are providing hospice services to the residents at Foulk Manor North, during quarterly care plan meetings or as necessary. D. The Director of Nursing will review all findings during the facility's Quarterly Quality Assurance Meetings.	8/17/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	08A011	A. BUILDING _____ B. WING _____	C 07/03/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIVE STAR FOULK MANOR NORTH LLC	1212 FOULK ROAD WILMINGTON, DE 19803

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 312	Continued From page 9	F 312		

"assist with oral care twice a day and monitor gums."

During an interview on 6/27/12 at 9:30 AM, R4 stated that her teeth were cleaned weekly.

On 6/29/12 at 9:04 AM, R4 was transported in her geri chair from her room to the hall and positioned facing the nurse's station by E10 (hospice CNA). Immediately following this observation, E10 was interviewed. E10 stated that she had just finished R4's "AM (morning) care". When asked what that included, E10 stated that she washed her up... and stated, "yes" that she had provided oral care and that R4 had her own electric toothbrush.

On 6/29/12 at 9:10 AM during an interview, R4 confirmed that she had been washed up, but denied having her teeth brushed. R4 stated, "They never do it..." R4 smiled and showed the surveyor her teeth which were observed to have multiple areas of food and debris to her front teeth and gums. There was no evidence that R4's teeth had been brushed despite E10's interview.

On 6/29/12 at 9:12 AM, E11 (nurse) was asked to look at R4's teeth. R4 smiled and showed her teeth to E11, who stated, "Oh, she needs mouth care." E11 immediately transported R4 to her room and provided oral care. Approximately 10 minutes later, E11 returned R4 to the area across from the nurse's station. R4 gave a big smile, showing her teeth to the surveyor as she passed by and stated, "That feels good... It should be done every morning."

During an interview on 6/29/12 at 9:25 AM, E2

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	08A011	A. BUILDING _____ B. WING _____	C 07/03/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIVE STAR FOULK MANOR NORTH LLC	1212 FOULK ROAD WILMINGTON, DE 19803

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 312	Continued From page 10 (Director of Nursing) acknowledged the findings and stated that she was contacting the case manager from hospice and would address this issue (lack of oral care) with the facility administrator.	F 312		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, it was determined that the facility failed to maintain an environment free of hazards such as a damaged wheelchair and doors to resident rooms, and the storage of unsecured oxygen canisters. Findings include: 1. On 6/28/2012 at 8:55 AM, observations of R5's electric wheelchair revealed that the head and back rest coverings were torn. E8 (Maintenance Worker) on 6/28/2010 at 9:15 AM repaired the tears using grey duct tape. 2. On 6/28/2012 at 8:55 AM, observations of the resident room 214 revealed that two (2) unsecured oxygen canisters were stored on the floor by the 214B bed. E7 (LPN) acknowledged the finding and removed the canisters.	F 323	A. On 6/28/12, the facility repaired the resident's torn wheelchair. On 6/28/12, the facility immediately removed the two (2) empty unsecured oxygen canisters. On 6/29/12, the facility immediately repaired the splintered doors of room 317, 201, 214, 312 and 314. The warped door in room 314 had loose screws on the hinges and were immediately tightened and repaired. B. The Maintenance Director or designee will in-service all maintenance and personnel on identifying damaged resident furniture, doors and equipment and understanding the process for submitting a work order for repair. The Director of Nursing will in-service all nursing personnel on proper storage and securing of oxygen canisters. C. The Maintenance Director and Director of Nursing or designee will conduct weekly environmental rounds to assess the quality of resident furniture, doors, equipment for damage and proper storage of oxygen canisters.	8/17/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	08A011	A. BUILDING _____ B. WING _____	C 07/03/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIVE STAR FOULK MANOR NORTH LLC	1212 FOULK ROAD WILMINGTON, DE 19803

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 11 3. On 6/29/2012 at 8:00 AM, observations and physical contact with the damaged laminate of the front door to resident room 317 resulted in a splinter to the surveyor's right hand. Additionally, the laminate to the front doors of resident rooms 201, 214, 312, and 314 were damaged. Also, the front door to resident room 314 was warped. In an interview on 7/2/2012 at 2:00 PM, E5 (Maintenance Director) confirmed the findings.	F 323	D. The Maintenance Director and Director of Nursing will review all findings during the facility's Quarterly Quality Assurance Meetings for six (6) months.	8/17/12
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to ensure that 1 resident (R12) out of 11 stage II sampled residents was free of any significant medication errors. Findings include: R12 had a diagnosis of hypertension. R12's physician had ordered Toprol XL 100 mg daily, a sustained release anti-hypertensive medication beginning 2/9/11. On 6/28/12, during a medication pass observation, E4 (RN) crushed Toprol XL for R12. The surveyor stopped E4 from administering the medication. Then, E4 checked the "Do Not Crush List" located in the from of the June Medication Administration Record (MAR). Toprol XL was on	F 333	A. The surveyor's observation prevented the identified nurse from administering the crushed medication. B. The Director of Nursing or designee will schedule an in-service for all licensed professionals to review the protocol for crushing medications. C. The Unit Manager or designee will make weekly observations during a medication pass to ensure that all medication protocols are being followed and report findings to the Director of Nursing. D. The Director of Nursing will review findings during the facility's Quarterly Quality Assurance Meetings for six (6) months.	8/17/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	08A011	A. BUILDING _____ B. WING _____	C 07/03/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIVE STAR FOULK MANOR NORTH LLC	1212 FOULK ROAD WILMINGTON, DE 19803

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 333	Continued From page 12 the list not to crush. On 6/28/12, in an interview, E4 acknowledged the findings.	F 333		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens	F 441	A. No residents were affected by this potentially deficient practice. B. The Staff Development Coordinator or designee will schedule an in-service to all nursing personnel on proper handwashing techniques. C. The Unit Manager or designee will conduct weekly observations to ensure that nursing personnel are using proper handwashing techniques and report findings to the Director of Nursing. Completion Date: October 16, 2012 D. The Director of Nursing will review all findings during the facility's Quarterly Quality Assurance Meetings for six (6) months. Completion Date: January 16, 2013	10/16/12 1/16/13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	08A011	A. BUILDING _____ B. WING _____	C 07/03/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIVE STAR FOULK MANOR NORTH LLC	1212 FOULK ROAD WILMINGTON, DE 19803

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 13 Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection for 2 residents (R2 and R3) out of 11 stage II residents. The facility failed to provide proper hand washing techniques to prevent the spread of germs and infection during care. Findings include: On 6/27/12 at 9:55 AM, E16 (CNA) was observed washing her hand in the tub room after transferring R3 using a stand up lift with E17 (CNA) to toilet the resident. However, E16 washed her hands and with the wet paper towels that she used to dry her hands, shut off the faucet, potentially recontaminating her hands. On 6/27/12, in an interview, E16 acknowledged the finding. On 6/29/12 at 8 AM, E18 (LPN) was observed washing his hands during a medication pass observation for R2. With the wet paper towels that he used to dry his hands, E18 shut off the faucet, potentially recontaminating his hands. On 6/29/12, in an interview, E18 acknowledged the finding.	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	08A011	A. BUILDING _____ B. WING _____	C 07/03/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIVE STAR FOULK MANOR NORTH LLC	1212 FOULK ROAD WILMINGTON, DE 19803

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

DELAWARE HEALTH AND SOCIAL SERVICES (DHSS)

Division of Long Term Care Residents Protection (DLTCRP)

DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 577-6661

STATE SURVEY REPORT

NAME OF FACILITY: Five Star Foulk Manor North

DATE SURVEY COMPLETED: July 3, 2012

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	An unannounced Annual and Complaint survey was conducted at this facility from June 26, 2012 through July 3, 2012. The deficiencies contained in this report are based on observations, interviews, review of resident's records and review of other documentation as indicated. The facility census the first day of the survey was 41. The survey sample totaled 17 residents.	Cross refer to the CMS 2567-L survey report date completed 7/3/12. F164, F280, F309, F312, F323, F333 and F441.
3201.1.0 **3201.1.2**	**Skilled and Intermediate Care Nursing Facilities** **Scope** **Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** **This requirement is not met as evidenced by:** Cross refer to the CMS 2567-L survey report date completed 7/3/12, F164, F280, F309, F312, F323, F333, and F441.	Completion Date: 8/17/12
F371	**483.5(i) Food Procurement, Store/Prepare/Serve - Sanitary**	

Provider's Signature [signature] Title Executive Director Date August 2, 2012

DELAWARE HEALTH AND SOCIAL SERVICES (DHSS)
Division of Long Term Care Residents Protection (DLTCRP)

DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 577-6661

STATE SURVEY REPORT

NAME OF FACILITY: Five Star Foulk Manor North

DATE SURVEY COMPLETED: July 3, 2012

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	The facility must – **(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions.** **This requirement is not met as evidenced by:** Based on observation, the facility failed to ensure that the dining floor was clean and food was delivered and served under sanitary conditions. Findings include: Prior to breakfast and during breakfast mealtime on 6/26/12, food debris was observed all over the third floor dining room floor. During a breakfast dining observation on the third floor unit on 6/26/12 at approximately 9:00 AM to 9:30 AM, the following were observed: E15 (CNA) was observed feeding a resident. Right after E15 finished feeding that resident, without washing hands went to another table to help feed R20. While feeding R20, E15 picked up a piece of the toasted bread with jelly using her bare hand and fed it to this resident. After feeding R20, E15 went to the food cart in the hallway and without washing her hands, took a food tray from the food cart and delivered it to R18's room. E15 placed the breakfast tray on R18's bedside table. Without washing her hands, she donned a pair of gloves, touched and repositioned R18's Foley catheter tubing	

NAME OF FACILITY: Five Star Foulk Manor North

DATE SURVEY COMPLETED: July 3, 2012

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	and bag. Then, E15 removed and discarded the gloves and fed R18 without washing her hands. The facility failed to serve food under sanitary conditions. This finding was discussed with and confirmed by E15 (CNA) and E4 (RN) on 6/26/2012.	